Medicaid Information Bulletin

April 2001

Visit the Utah Medicaid Program on the World Wide Web: www.health.state.ut.us/medicaid

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This bulletin is available in editions for people with disabilities.
Call Medicaid Information: 538-6155 or toll free 1-800-662-9651.

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01 - 34 Deadline to Return New Medicaid Provider Agreement: May 31, 2001

We would like to remind all providers that only the new Medicaid Provider Agreement dated January 1, 2001, can be accepted to enroll or to remain enrolled in Utah Medicaid. The new agreement supersedes all previous agreements. The deadline to return the new, signed agreement is May 31, 2001.

On January 22nd, Medicaid mailed the new agreement to enrolled providers. All providers must sign an agreement for each provider number they use to bill Utah Medicaid. Some providers will sign multiple agreements, one for each provider number they maintain.

We thank those of you who have already returned your completed agreement and remind the rest of you to return it immediately. Complete the first and last pages of the agreement. Put the 12 digit provider number found on the colored insert sheet on the line titled "Medicaid/UMAP Provider Number" on page 6. REMINDER: MEDICAID CANNOT ACCEPT ANY AGREEMENT THAT HAS BEEN ALTERED OR CHANGED IN ANY WAY.

Continued on page 2

Return the entire agreement to Medicaid Operations by mail or FAX:

Mailing address

Bureau of Medicaid Operations
Provider Enrollment
P.O. Box 143106
Salt Lake City, UT 84114-3106

FAX number: (801) 536-0471

Thank you for your participation with the Utah Medicaid program and for your interest in providing services to Utah Medicaid recipients. Contact Provider Enrollment* if you have any questions about the agreement.

Attention Billing Agents and Outreach Employees

Please destroy any old stock of Utah Medicaid application packages and replace them with the January 2001 application package with the new agreement and civil rights information. You can obtain new application packages by calling Provider Enrollment*.

Provider Agreement Available on Internet

You can download a copy of the new agreement from the Medicaid web site. The specific address for the Provider Agreement is
www.health.state.ut.us/medicaid/agreement.pdf

Termination of Medicaid Provider Agreement

On June 1, 2001, Medicaid may close all provider numbers which still do not have a new, signed agreement. Until then, Medicaid will continue to try to obtain a new agreement from every provider.

*** Provider Enrollment:** Call Medicaid Information at (801) 538-6155 or (800) 662-9651. Select menu option 3, then menu option 4. ☐

01 - 35 Electronic Copies of Medicaid Information Bulletins and Index

Medicaid Bulletins published since April 1997 are on the Internet. You can find the links to both the current and past bulletins at:
http://www.health.state.ut.us/medicaid/html/provider.html

There is also an Index to Medicaid Information Bulletins on the Internet. The Index has an alphabetical list of articles by keywords and title and also a chronological list of bulletins by date published. The Index is at:
http://www.health.state.ut.us/medicaid/IndexMIBs.pdf ☐

Medical Interpretive Services: Toll-free Phone Number Added for Pentskiff Interpreting Services

A toll-free number has been added to the Guide to Medical Interpretive Services for Pentskiff Interpreting Services: 1-800-246-7127. The local number is (801) 484-4089. Hours: 24 hours a day, 7 days a week, 365 days a year. You can download a corrected guide from the Internet at
http://www.health.state.ut.us/medicaid/interpreter.pdf

01 - 36 DRG Payment Methodology for Urban Hospitals

Beginning July 1, 2001, Utah Medicaid will begin paying urban hospitals under a revised payment methodology. The new methodology is a result of over two years of discussions and analysis with representatives of the hospital industry. The Utah Hospital and Health Systems Association (UHA) facilitated regular monthly meetings of the task force.

This new payment methodology affects only urban fee-for-service claims. Reimbursement to rural hospitals will continue as in the past. While Medicaid HMOs may choose to make payments based upon this new methodology, they are not required to do so. (HMOs have their own provider agreements). Most fee-for-service claims are for persons who present themselves at a hospital for care and afterwards become eligible for Medicaid to cover the cost of medical services. Once eligible, Medicaid clients are usually enrolled in an HMO for continued Medicaid services.

The new payment methodology includes the following features:

1. New DRG weights based upon recent data.
2. Elimination of the day outlier (everything is paid under a DRG).
3. An outlier payment for charges that exceed 2.5 times the DRG payment.
4. New Medicaid DRGs for selected neonates based upon birth weights.
5. Separate payment adjustments for Graduate Medical Education, UMAP and Disproportionate Share.
6. Elimination of the current hospital specific factor.

Two meetings are scheduled to explain in detail the methodology and allow hospital representatives to ask questions to understand it. Those meetings are Thursday, May 31, 2001 at 9:00am and Tuesday, June 5, 2001 at 9:00am. Both meetings are in Room 125 of the Cannon Health Building (288 North 1460 West, Salt Lake City, Utah).

For further information, contact Randy Baker, Associate Actuary, at (801) 538-6733. ☐

01 - 37 Health Common Procedure Coding System - 2001 Revisions

Effective for dates of services on or after January 1, 2001, Medicaid begins accepting the 2001 version of the Health Common Procedure Coding System (HCPCS). HCPCS codes include the 2001 Physicians' Current Procedural Terminology (CPT) codes. Continue to obtain prior authorization required for procedures on the 2000 list, even though new codes may be added for the same or similar procedures, or codes may be changed on the 2001 list.

The April 2001 Medicaid Information Bulletin will contain details about coding changes for services by physicians, medical suppliers and so forth. Any 2000 HCPCS codes discontinued in 2001 may be used for dates of services prior to April 1, 2001. For services on and after April 1, 2001, providers must use the 2001 HCPCS codes. If you have a question concerning billing the 2001 HCPCS codes, please contact Medicaid Information. □

01 - 38 Laboratory Codes; Fetal Lung Maturity Assessment

Code 83020, Hemoglobin fractionation and quantization; electrophoresis, was open for technical, but not professional component, which was an error. Therefore, the professional component is added for this code.

Code 83021, Hemoglobin fractionation and quantization; chromatography, was open for both the technical and professional components, which was in error. The professional component is not covered; only the technical component will receive reimbursement.

Fetal lung maturity assessment

Medicaid will cover Fetal Lung Maturity (FML) tests 83661 (L/S ratio), 83662 (foam stability test), and 84081 (phosphatidglycerol) until October 31, 2001. As of November 1, providers must use one of the new FML tests: 83663 Flourescence Polarization or 83664 Lamellar body density. □

01 - 39 Codes NOT Authorized for an Assistant Surgeon

The list Codes NOT Authorized for An Assistant Surgeon in the Utah Medicaid Provider Manual for Physician Services has been updated to include changes introduced by HCPCS 2001. (Codes on this list may be covered by Medicaid but are NOT covered for an assistant surgeon.) Discontinued codes are removed, and new codes are added. Providers of physician services will find a new list attached. For more information regarding the effective dates of revisions, refer to Bulletin 01 - 37, Health Common Procedure Coding System - 2001 Revisions.

Codes Discontinued

The CPT codes which follow are removed from the list because they are discontinued: 52335, 52336, 52337, 52338, 52340.

Codes Added to List "NOT Authorized for An Assistant Surgeon"

The following codes are NOT covered for an assistant surgeon and have been added to the list:

15342	45341	58353	76012
15343	45342	64614	76013
16036	45345	64708	76818
19102	45387	67221	76819
19103	50947	71551	84591
19295	50948	71552	86001
21199	50949	72195	86301
22520	52341	72197	86316
22521	52342	73206	87300
22522	52344	73218	87451
29826	52351	73219	89321
30465	52352	73222	90940
33140	52353	73223	91132
33141	52354	73706	91133
36870	54512	73718	93668
44370	54522	73719	97602
44379	55873	73722	97802
44383	55899	73723	97803
44397	57022	74182	97804
45327	57023	74183	99172

□

01 - 40 Medicaid and Other Third Party Coverage: Accepting Patients with Dual Coverage

When a Medicaid client also has some other third party insurance, a provider may either accept the patient as having dual coverage OR not accept either type of coverage. Of course, the Medicaid agency urges that providers accept the client as a Medicaid client, then follow the procedures outlined in the Utah Medicaid Provider Manual for billing TPL.

SECTION 1 of the Utah Medicaid Provider Manual, Chapter 6 - 5, is amended to include the regulation on clients with dual coverage. The revision is as follows:

6 - 5 Liable Third Parties

A liable third party is any person or entity such as health insurance, a health maintenance organization, or Medicare, which may be responsible for services rendered to a Medicaid patient. This information is available from Medicaid and is printed on the Medicaid Identification Card. Refer to Chapter 5 - 5, Third Party Liability.

1. Medicaid and Other Third Party Coverage: Accepting Patients with Dual Coverage

When a Medicaid client also has some other third party insurance, a provider may either accept the patient as having dual coverage OR not accept either type of coverage. Federal Medicaid regulations do not permit a provider to reject Medicaid and accept only the other third party coverage. A provider can only refuse Medicaid and insist the client must be "private pay" IF there's no other third party coverage. Of course, the Medicaid agency urges that providers accept the client as a Medicaid client, then follow the procedures outlined in the Utah Medicaid Provider Manual for billing TPL. Refer to SECTION 1, Chapter 11 BILLING CLAIMS.

Reference: 42 CFR 447.20 (b)

2. Correcting Third Party Information

If information about the responsible third party appears to be incorrect (for example, the TPL denies a claim as "patient not eligible"), the provider should advise the patient to call the TPL unit in the Office of Recovery Services at the Department of Human Services. Providers may also call the Office of Recovery Services to advise them of correct third party liability information. The telephone number is printed on the bottom of the Medicaid Card and also listed in Chapter 5 - 5, Third Party Liability. Refer to Chapter 11 - 4, Billing Third Parties, for information on billing TPL and coordination with Medicaid.

SECTION 1 available on Internet

The corrected SECTION 1 is available on the Internet at www.health.state.ut.us/medicaid/SECTION1.pdf. ☐

01 - 41 Medicaid Budget Hearing for Fiscal Year 2002

The Department of Health invites you to a special Medical Care Advisory Committee (MCAC) meeting to obtain public input on the Medicaid and UMAP (Utah Medial Assistance Program) budgets for Fiscal Year 2002. The meeting will be held Thursday, July 19, 2001 from 4:00 p.m. until 6:00 p.m. at the Cannon Health Building, 288 N. 1460 W., in Room 114.

Note: The Cannon Health Building is a secured building. Access Room 114 directly by entering the **east** entrance by the Health Clinic and Day Care. If you choose to use the main entrance on the south side of the building, you must obtain a visitor's pass and be escorted to room 114.

Fiscal Year 2002 is July 1, 2001 through June 30, 2002. The MCAC is an advisory group which recommends funding and program directions to the Department of Health and the Governor.

If you know of special medical needs not being met by the Medicaid or UMAP programs, or want to speak on a budgetary matter of importance to you, please come prepared to make a short (no more than five minutes) presentation to the Committee. Copy services will be provided if you have a handout. SIGNED PETITIONS ARE ENCOURAGED. Your input will assist the MCAC in recommending a budget that will be more representative of Medicaid and UMAP providers and clients.

If you cannot attend the public hearing, but would like to write to the MCAC Committee about special medical needs, please mail your comments by Monday, July 02, 2001, to:

MCAC Committee
Division of Health Care Financing
Box 143103
Salt Lake City, UT 84114-3103

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01 - 42 Home Health Services: Rural Area Home Health Travel Enhancement

Effective May 1, 2001, Medicaid will provide enhancements to the home health reimbursement rate when travel distances to provide services are extensive. The enhancement is available only in rural counties where round-trip travel distances from the care giver's base of operations are in excess of 25 miles. Rural counties are defined as counties other than Weber, Davis, Salt Lake, and Utah counties. For round trip travel of 25 miles or more, the home health fee schedule will be multiplied by 1.75 to calculate the payment rate for applicable service codes.

To receive the rural home health travel enhancement, home health agencies must file the claim using the applicable, approved service code listed in Chapter 6 with a modifier "22". For example, code Y0103 with modifier "22" (Y0103 22).

Home Health Manual Updated

SECTION 2 of the Utah Medicaid Provider Manual for Home Health Services has been updated to include the information on enhancements to the home health reimbursement rate. The information is added as a new chapter 4 - 6, Rural Area Home Health Travel Enhancement. The subsequent chapter is renumbered as 4 - 7,Telehealth Skilled Nurse Pilot Project for Patients in Rural Areas. Providers will find attached three pages to update their manual. ☐

01 - 43 Wheelchairs, Customized and Motorized: Clarification of Policy

Medicaid has redefined the categories for wheelchairs to the Medicare categories and definitions: Standard, Customized, and Motorized. The term "specialized" is no longer used by Medicaid as a definition or category. SECTION 2, Medical Supplies, Chapter 2 - 9, Wheelchairs, of the Utah Medicaid Provider Manual for Medical Supplies has been revised. The updated pages are attached. Remove existing pages 26 through 35 and replace with pages 26 through 35B. A vertical line in the margin of a page indicates where text was changed or added. An asterisk (*) marks where text was deleted.

Where appropriate, the term "nursing home" has been replaced by the term "long term care facility." Health care providers in this area of service indicate a preference for "long term care facility" as a more appropriate descriptor. ☐

01 - 44 Dental Claim: Current ADA Form Required (1994, 1999 Versions)

Effective July 1, 2001 Medicaid will accept only current dental claim forms; that is, ADA versions 1994 and 1999. Dental claims submitted on forms older than the ADA 1994 version will not be processed. They will be returned to the provider. Requiring current ADA forms facilitates the entry of data into the computer and increases efficiency and cost effectiveness of the claims adjudication process.

We appreciate your cooperation in using the current ADA forms. ☐

01 - 45 Anesthesiologists: ASA Code List Updated

Two American Society of Anesthesiologists (ASA) codes have been added to the Medicaid list titled ASA Codes Associated With CPT Surgical Codes Which May Require Prior Authorization. This list is an attachment to the Utah Medicaid Provider Manual for Physician Services. The two codes are:

00402 Anesthesia for reconstructive breast procedures (reduction, augmentation, muscle flaps)

00580 Anesthesia for heart transplant or heart-lung transplant

Physicians will find an updated code list attached to update their manual. A vertical line in the margin marks where text was added to the list. ☐

01 - 46 Audiology Services: Replacement of Hearing Aids

Durable medical equipment (DME), including hearing aids, may not be replaced more often than every five years unless prior approved. DME is expected to last for at least five years under normal use. This reminder of existing policy is added to SECTION 2, Audiology Services, Chapter 3 - 2, Hearing Aids.

Audiologists will find attached a revised page to update their manual. ☐

01 - 47 Year 2001 CPT Codes

The Medical and Surgical Procedures List in the Utah Medicaid Provider Manual for Physician Services has been updated in accordance with Year 2001 Current Procedural Terminology (CPT) codes. The list includes codes which are not covered by Medicaid, or require prior authorization, or have other limitations. This bulletin summarizes the changes to the list. HCPCS descriptors, abbreviated in this bulletin, are stated in full on the Medicaid list.

The last section of this bulletin explains how to update the Medical and Surgical Procedures List. For more information on the effective dates of this year's revisions, refer to Bulletin 01 - 37, Health Common Procedure Coding System - 2001 Revisions.

CPT Codes Not Covered

Medicaid does not cover the CPT codes listed below. The Medicaid list states these codes are "NOT A BENEFIT."

21199 Osteotomy mandible; segmental; . . .
22520 Percutaneous vertebroplasty, one vertebral body
22521 Percutaneous vertebroplasty, one vertebral body
22522 Percutaneous vertebroplasty, Add on code . . .
30465 Repair of nasal vestibular stenosis . . .
33141 Transmyocardial laser revascularization . . .
36540 Collection of blood specimen f . . .
43752 Naso- or Oro-gastric tube placement . . .
44132 Enterectomy . . .
44133 Enterectomy . . .
61885, 61886 Incision and subcutaneuous placement of cranial neurostimulator pulse generator or receiver, . . .
69714 Implantation, osseointegrated implant, . .
69715 Implantation, osseointegrated implant, . .
69717 Replacement (including removal of existing device), . . .
69718 Replacement (including removal of existing device), . . .
71551 MRI chest . . .
71552 MRI chest . . .
73206 CT angiography . . .
73218 MRI upper extremity . . .
73219 MRI upper extremity . . .
73222 MRI any joint of upper extremity . . .
73223 MRI any joint of upper extremity . . .
73706 CT angiography . . .
73718 MRI lower extremity . . .
73719 MRI lower extremity . . .
73722 MRI any joint of lower extremity . . .
73723 MRI any joint of lower extremity . . .
74182 MRI abdomen with contrast material
74183 MRI abdomen, without contrast material . . .
76012 Radiological supervision and interpretation . . .
76013 Radiological supervision and interpretation . . .
86301 Immunoassay tumor antigen quantitative
86316 Immunoassay tumor antigen, quantitative . . .
89321 Semen analysis, . . .
90940 Hemodialysis access flow study . . .
91132 Electrogastrography, diagnostic transcutaneous
91133 Electrogastrography diagnostic, transcutaneous
93668 Peripheral arterial disease (PAD) rehabilitation
97602 Removal of devitalized tissue from wound, . .
97802 Medical nutrition therapy; . . .
97803 Medical nutrition therapy; . . .
97804 Medical nutrition therapy; . . .
99172 Visual function screening, . . .

Code no longer covered

Code 33140, transmyocardial laser revascularization, by thoracotomy, is not covered by Medicaid. The note on the Medical and Surgical Procedures List by this code that said "covered under very limited circumstances" has been removed.

"S" and "G" Codes Non-Covered

"S" and "G" codes are Medicare codes. Comparable CPT codes are available and used by Medicaid. "S" and "G" codes are covered only when submitted as a crossover claim except when federally mandated, such as G0001.

Codes Discontinued

The following codes are discontinued and have been removed from the Medicaid list: 92597, 92598, 97770, 99375, 99378.

CPT Codes Requiring Prior Authorization

The CPT codes listed below are covered only with prior authorization, either written or telephone as indicated. Criteria are stated on the replacement pages dated April 2001.

Telephone Prior Approval Required for Codes
55530 Excision of varicocele or ligation of spermatic veins for varicocele . . .
55535 Excision of varicocele or ligation of spermatic veins for varicocele . . .
55540 Excision of varicocele or ligation of spermatic veins for varicocele . . .
55899 Unlisted procedure, male genital system
58353 Endometrial ablation, thermal, . . .

Written Prior Approval Required for Codes Listed below

* 44135 Intestinal allotransplantation . . .
* 44136 Intestinal allotransplantation . . .
54522 Orchiectomy, partial . .
**61888 Revision or removal of cranial neurostimulator pulse generator or receiver, . . .
**63043 Laminotomy, each addition cervical interspace
**63044 Laminotomy, each addition lumbar interspace
**64573 Incision for implantation of neurostimulator electrodes; cranial nerve
**64585 Revision or removal of peripheral neurostimulator electrodes
**64590 Incision and subcutaneous placement of peripheral neurostimulator pulse generator receiver, direct of inductive coupling.
**64595 Revision or removal of peripheral neurostimulator pulse generator receiver

***** A new **Criteria #31** for intestinal transplants has been developed for use with codes 44135 and 44136.

******A new **Criteria #32** for neurostimulators for epilepsy will be available by April 1 for use with codes 61888, 64573, 64585, 64590 and 64595. Find a link to Criteria #32 on http://www.health.state.ut.us/medicaid/html/what_s_new.html or call Medicaid Information to request a copy.

CPT Codes Requiring Documentation with Claim

The CPT codes listed below do not require prior authorization. However, each one does require that the provider attach documentation to the claim. Descriptors in the list below are abbreviated. For more information on unlisted codes, refer to Bulletin 01-37 Unspecified Services and Procedures.

23929 Unlisted Procedure; Shoulder
33999 Unlisted procedure, Cardiac surgery (Note: Radio frequency ablation is NOT a benefit.)
41599 Unlisted Procedure; tongue, floor of mouth
47379 Unlisted laparoscopic procedure, liver (Note: Radio frequency ablation is NOT a benefit.)
50949 Unlisted laproscopic procedure, ureter
64999 Unlisted procedure, nervous system
68399 Unlisted procedure, conjunctiva
72195 MRI pelvis without contrast material
72197 MRI pelvis without contrast . . . .
76818 Fetal biophysical profile; . . . .
76819 Fetal biophysical profile, ...
84591 Vitamin, not otherwise specified
86001 Allergen specific IGG . . . .
87300 Infectious agent antigen detection . . . .
87451 Infectious agent antigen detection . . . .

Codes with Descriptor Changes

Descriptors for the following codes on the list have been corrected in accordance with HCPCS 2001: 58943, 58950, 58952, 63040, 63042, 70540, 71550, 73220, 73221, 83013, 87797, 87798, 87799, 99374.

Replacement Pages

Providers of physicians services will find attached the corrected replacement pages for the Medical and Surgical Procedures List dated April 2001. New codes are in bold print. A vertical line in the margin marks where text was changed or added. An asterisk (*) marks where text was deleted.

Replace pages 1 - 2 and 13 through 56. Add new Criteria #31 as pages 79 - 80. Corrections are effective January 1, 2001, in accordance with instructions for use of the 2001 HCPCS codes. For more information on effective dates, refer to Bulletin 01 - 37, Health Common Procedure Coding System - 2001 Revisions. ☐

01 - 48 Unspecified Services and Procedures

We want to remind you that unspecified or nonspecific procedure codes have limitations and specific requirements for payment. The requirements are stated in SECTION 1 of the Utah Medicaid Provider Manual, Chapter 9 - 1, Unspecified Services and Procedures. The same policy is repeated on page 3 of the Medical and Surgical Procedures List. Briefly, policy states,

> "Do not use unspecified service or procedure codes to provide services which are not a Medicaid benefit. . . Submit documentation for these codes with the claim form for prepayment review. Documentation should include medical records, such as the operative report, patient history, physical examination report, pathology report, and discharge summary, which provide enough information to identify the procedure performed and to support medical necessity of the procedure."

In the past, unspecified codes often ended in the digits '99'. However, unspecified codes may end in other digits. Providers are expected to identify unlisted codes by descriptor and adhere to Medicaid policy.

Unlisted codes newly added to the Medical and Surgical Procedures List are in the preceding bulletin (01 - 47 Year 2001 CPT Codes) in the sub-section titled "CPT Codes Requiring Documentation with Claim."

Prior Approval or Non-Covered

Like any other CPT code, an unlisted code may require prior approval or be non-covered. If so, this is stated on the Medical and Surgical Procedures List.

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01 - 49 Injectable Medication Codes

This bulletin describes coverage of injectable medication codes (J - codes) included in the 2001 Health Common Procedure Coding System (HCPCS) procedure codes update. Reimbursement to physicians for these codes is made at 5% below Medicare's participating physician's allowable cost. HCPCS descriptors for covered codes, abbreviated in this bulletin, are given in full in the code list. Injectable medications which are not on the Medicaid Injectable Medications List are NOT covered by Medicaid.

For information on the effective dates of code changes, refer to Bulletin 01 - 37, Health Common Procedure Coding System - 2001 Revisions.

Discontinued Codes

The following codes are discontinued and have been removed from the Injectable Medications List: J1562, J2996, J7610, J7615, J7620, J7625, J7627, J7630, J7640, J7650, J7651, J7652, J7653, J7654, J7655, J7660, J7665, J7670, J7672, J7675

Codes Added

Codes covered by Medicaid are listed below in numerical order with a brief descriptor.

J0282 Amiodarone Hydrochloride, 30 mg
J1563 Immune Globulin, Intravenous, 1g
J2770 Quinupristin/dalfopristin, 500 Mg (150/350)
J2795 Ropivacaine Hydrochloride, 1 mg
J2915 Sodium Ferric Gluconate Complex . . .
J2997 Alteplase Recombinant, 1 mg
J3485 Zidovudine, 10 mg
J7520 Sirolimus, Oral, 1 Mg
J7525 Tacrolimus, Parenteral, 5 mg
J8700 Temozolmide, Oral, 5 mg
J9160 Denileukin Diftitox, 300 Mcg
J9180 Epirubicin Hydrochloride, 50 mg
Q0136 Epoetin alpha, (for non esrd use). . .
Q2010 Glatiramer acetate, per dose
S0085 Gatifloxacin, 200 mg

Codes With Prior Authorization Requirement

Codes listed below are covered by Medicaid only with prior authorization. Criteria are on the chart at the end of the Injectable Meditations List.

J1452 Fomivirsen Sodium, Intraocular, 1.65 mg
J2993 Reteplase, 18.8
S0086 Verteporfin, 15 mg

Descriptors Revised

Descriptors for the following codes were revised: J0895, J1100, J2260, J2543, J3010, J7505, J7618, J7619.

Injectable Medications List Updated

An updated Injectable Medications List for the Utah Medicaid Provider Manual for Physician Services is attached for physicians, licensed nurse practitioners, and osteopaths. Other providers who want the revised list should contact Medicaid Information; ask for the April 2001 Injectable Medications List. ☐

01 - 50 Utah Teen Tobacco Quit Line: Telephone-based Resource for Teenagers

The Tobacco Prevention and Control Program is pleased to announce free, statewide, telephone-based tobacco cessation counseling for ALL Utah teenagers. The Utah Teen Tobacco Quit Line (Teen Quit Line) is confidential and easy to use. Parents and friends of teens can also receive assistance in how to help their teen/friend quit tobacco.

The Teen Quit Line is a great referral resource for health care providers. It provides screening, counseling, support materials and referral to additional cessation assistance when appropriate. We encourage you to actively promote the Teen Quit Line to tobacco-using teens and concerned parents.

Tobacco Quit Line (Teen Quit Line) 1-888-567-TRUTH
1-888-567-8788
Hours of operation are:
Monday – Thursday, 10:00 a.m. – 9:00 p.m.
Friday, 10:00 a.m. – 6:00 p.m.
Saturday, 10:00 a.m. – 2:00 p.m.

Ads promoting the Teen Quit Line have been airing on radio and TV, as part of the "Truth About Tobacco" media campaign. If you would like promotional materials (such as business cards and flyers) to help inform patients, please contact the Tobacco Prevention and Control Program. The program's toll-free number is 1-877-220-3466. ☐

01 - 51 Hospital Surgical Procedures (ICD-9-CM Codes)

Effective January 1, 2001, the Hospital Surgical Procedures Code List was updated to add

- Eight ICD-9 codes
- CPT codes related to these ICD-9 codes
- Criteria #31 (Intestinal Transplantation)
- Criteria #32 (Neurostimulators for Epilepsy), available by April 1. Find a link to Criteria #32 on http://www.health.state.ut.us/medicaid/html/what_s_new.html or call Medicaid Information to request a copy.

The new ICD-9 codes and the CPT codes to which they are related are listed below. (The CPT descriptor is abbreviated.) Prior authorization (PA) is required for the CPT codes.

ICD-9 Code: 46.97, Transplantation of intestine.

Related to CPT codes (written PA): 44135, 44136, Intestinal allotransplantation . . .

ICD-9 Codes: 04.92, Implantation or replacement of peripheral neurostimulator; 04.93, Removal of peripheral neurostimulator; 345.41 and 345.51, Partial epilepsy, .

Related to CPT codes (written PA): 61888, Revision or removal of cranial neurostimulator . . . ; 64573, Incision for implantation of neurostimulator electrodes . . . ; 64585, Revision or removal of peripheral neurostimulator electrodes; 64590, Incision & subcutaneous placement of peripheral neurostimulator . . . ; 64595, Revision or removal of peripheral neurostimulator . . .

ICD-9 Code: 63.1, Excision of varicocele and hydrocele of spermatic cord

Related to CPT codes (telephone PA): 55530, 55535, 55540, Excision of varicocele or ligation of spermatic veins for varicocele . . . ; 55899, Unlisted procedure, male genital system.

ICD-9 Code: 68.12, Hysteroscopy

Related to CPT code (telephone PA): 58353, Endometrial ablation, . . .

ICD-9 Code: 80.51, Excision intervertebral disc

Related to CPT codes (written PA): 63001, 63003, 63005, 63011, 63012, 63015, 63016, 63017: Laminectomy; 63020, 63030, 63035, 63040, 63042, 63043, 63044, 63045, 63046, 63047, 63048: Laminotomy;

63055, 63056, 63057: Transpedicular approach;

63064, 63066: Costovertebral approach

63075, 63076, 63077, 63078 Diskectomy

ICD-9 Code: 80.52, Intervertebral chemonucleolysis
Related to CPT codes (written PA): 62287, Aspiration procedure, percutaneous, . . .; 62292, Injection procedure of chemonucleolysis , . . .

Codes with Descriptor Changes

Descriptors for the following CPT codes are corrected as per HCPCS 2001: 58943, 58950, 58952.

Hospital Surgical Procedures List Updated

Providers of hospital services will find pages attached to update the Hospital Surgical Procedures List. Codes in bold print are newly added. A vertical line in the margin indicates where text was added on pages 27 - 28.

□

01 - 52 Speech Augmentative Communication Devices

Utah Medicaid will authorize Speech Augmentative and Alternative Communication Devices as speech language therapy services only when medical necessity criteria are met, as defined in the Utah Medicaid Provider Manual for Speech - Language Services, SECTION 2, Chapter 2 - 5. Medicaid may coordinate the purchase of the device with other payers when the client has significant educational or vocational needs.

Codes for Speech Augmentative Communication Devices

Use the following codes to bill:
K0544 SACD
K0546 SACD Mount
K0547 SACD Accessories

Speech and Language Manual Updated

Providers will find attached SECTION 2, Speech and Language Services, to update their Medicaid Provider Manual. Pages dated April 2001 have been revised. A vertical line on the page in the margin indicates where text was added. Changes were made to:

- Table of Contents, page 1.
- Chapter 2 - 5, pages 6 through 9
- Procedure codes for speech - language services
- Index, page 16.

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01 - 53 Medical Supplies List Revised

This bulletin describes coverage of medical supply codes included in the 2001 Health Common Procedure Coding System (HCPCS) procedure codes update. Only codes which are on the Medical Supplies List are covered by Medicaid. For more information on the effective dates for HCPCS updates, refer to Bulletin 01 - 37, Health Common Procedure Coding System - 2001 Revisions.

Also, as announced in Bulletin 01 - 22, Medical Supplies: Respiratory Assist Device, published January 2001, there are two corrections on page 33 of the Medical Supplies List (category "Oxygen and Related Respiratory Equipment"). Codes K0532, Respiratory assist device w/o backup rate, and K0533, Respiratory assist device with backup rate, are available for rental only. They are not available for purchase. These codes are changed to K0532LR and K0533LR, respectively.

Non-Covered Codes

Medical supply codes which are not on the Medical Supplies List are **not** covered by Medicaid.

Changes to the Medical Supplies List

Code deletions, revisions, and additions are summarized in the table below. HCPCS descriptors for covered codes are abbreviated in this bulletin. Codes are grouped according to their category on the Medical Supplies List.

Medical suppliers and providers of physician services will find attached an updated Medical Supplies List. New codes are in bold print. A vertical line in the margin of a page indicates where text was changed or added. (Medical suppliers, please note: When replacing the Medical Supplies List, be sure to keep the DMERC lists in your Medical Supplies Manual.)

Urinary Catheters

A4324 Male external catheter, . . .
A4334 Urinary catheter anchoring device ,. . .
A4325 Male external catheter . . .
A4334 Urinary catheter anchoring device ,. . .
A4348 Male external catheter . . .

Pumps

A4231 Limit increased to 10 per month

Enteral, Parental Nutrition

Y4025 Mic-Key/button for gastric. Limit is 2 per year.
Y4026 Mic-key./button tubing, Limit is 4 per year.

Nutrients

B4150 through B4156, descriptors updated

Ambulation Devices

E0148 walker, heavy duty, without wheels. . .
E0149 walker, heavy duty, wheeled, . . .

Bathroom Equipment

E0168 Commode chair, . . .

Decubitus Care

A6021 Collagen dressing, . . .
A6022 Collagen dressing, . . .
A6023 Collagen dressing, . . .
A6024 Collagen dressing wound filler, . . .
A6231 Gauze, impregnated, hydrogel, . . .
A6232 Gauze, impregnated, hydrogel, . . .
A6233 Gauze, impregnated, hydrogel . . .

Hospital Beds and Accessories

E0298 Hospital bed, heavy duty, extra wide, . . . Prior authorization required. Refer to Medical Supplies List for criteria.

Oxygen & Related Respiratory Equipment

E0424LR, E0441, E0431LR, E0443, E0439LR, E0442: descriptors updated.

Humidifiers and Nebulizers

A7501 Tracheostoma valve, . . .
E0574 Ultrasonic generator with small volume ultrasonic nebulizer
E0575 descriptor changed
E1375 discontinued effective 4-01-01

Lower Limb: Hip, Knee, Ankle

L1600, L1620, L1660, L1800, L1830, L1832, L1834, L1850, L1870, L1880, L1902, L1904, L1906, L1910, L1930, L1940, L1960, L1970, L1990, L2000, L2020, L2036, L2060, L2080: descriptors updated.

Additions to Lower Extremity: Orthoses

L2108, L2136, L4350: descriptors updated.

Upper Limb

L3650, L3670, L3675, L3700, L3800, L3908, L3980, L3982, L3986, L3890: descriptors updated.

Prosthetics, Lower Limb

L5674, L5979: descriptors updated.

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